# Provider identification number application

blue of california

☐ New provider number for individual Or ☐ Group or business entity
☐ Provider number for additional location (individual or group)
☐ Change existing information for provider No. _____
☐ Add to group provider No. _____

**Return to:**
Provider Services Department
Blue Shield of California
P. O. Box 629017
El Dorado Hills, CA 95762-9017
**(800) 258-3091** or Fax: (916) 350-8860

**Important:** Read reverse side before mailing. All information must be completed or marked n/a. Please type or print. Provider's signature is required.

## A. Provider of service information

Name (if application is for an individual or sole proprietor)
Last | First | Middle

Gender ☐ Male ☐ Female

Name (if application is for a group, business or corporation)

**Physical location address**
A separate provider number will be assigned for each location. Please notify us of each location by application or letter signed by provider

Number | Street | Suite

City | State | ZIP code

Fax No. ( ) –

Wheelchair access ☐ YES ☐ NO

E-mail address

Title/degree

License number

Primary specialty/type of service

Secondary specialty

Language(s) spoken

Physical location phone number ( ) –

TDD: Telecommunications device for the deaf ( ) –

## B. Billing reimbursement information

Billing or reimbursement address. Mail check to:

Number | Street | Suite

City | State | ZIP code

Billing location phone number ( ) –

Social Security number

Tax ID/Employer ID number required for group or business

Provider NPI number/Type

Tax identification Please check the box that best describes your type of business:
☐ Sole proprietorship without employees ☐ Medical supply retail (see reverse #5)
☐ Sole proprietorship with employees ☐ Medical supply rent/lease
☐ Corporation (please submit articles of incorporation)

Indicate prior practice addresses or groups no longer affiliated with: Attach a separate piece of paper if necessary.

Name and address | Provider/license number

Person authorized to sign for provider (if any)

Name | Title

If this application is for a group or corporation, please provide the full name and provider identification or license number for all licensed professionals providing services. If the individual does not have a provider number the individual must sign and submit a separate provider identification form before they can be added to the group. Attach a separate sheet of paper if necessary.

Name | Provider/license number

## C. Provider signature

This is to certify that all information included on this form is true, accurate, and complete.

I understand that any false statements, the concealment of material fact, or the use of false documents may lead to prosecution under applicable federal or state laws. I certify under penalty of perjury that the foregoing is true and correct. Read section D on reverse side of this application before signing.

**X** _____ _____ _____
Signature | Title | Date

Return white copy and retain yellow copy for your records

## Important information

Receipt of a Provider Identification Number does not mean that you are a "participating" provider. The Provider Identification Number is for billing purposes only. For information on becoming "participating," contact Provider Services: **(800) 258-3091**

## Section D

Additional documentation required to process your application and issue a Provider Identification Number is detailed below.

1. If exempt from licensure, include proof of exemption.
2. If state licensure of certification is required in order for you to provide health care products or services, include a photocopy of the current valid state license and/or a photocopy of your license issued by the Department of Health and Human Services.
3. If accredited by the Joint Commission on Accreditation of Hospitals (JCAH), include a photocopy of the JCAH approval letter or certificate.
4. If accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), include a photocopy of the AAAHC approval letter or certificate.
5. If selling medical equipment or supplies, include a photocopy of your Retail Sales Permit. If exempt from licensure please explain or provide proof of exemption.
6. If providing ambulance services, include a photocopy of your license to operate emergency ambulance from the California Highway Patrol and proof that the service is owned and operated by a Federal, State, County, or local government. If providing advanced life support services, also include a qualifying letter from the county where services are provided.
7. If you are incorporated, please submit Articles of Incorporation with this application.
8. If using a fictitious name:
    A. Physician, Podiatrists, Osteopaths, Dentists, and Optometrists include a photocopy of your Fictitious Name Permit from the State Licensing Board.
    B. Dispensing Opticians and Chiropractic corporations, include a photocopy of your Certificate of Registration from the State Licensing Board.
    C. All other providers, if you are incorporated and using an incorporated name, only a photocopy of your Articles of Incorporation are required. If you are not incorporated and using a fictitious name, a Fictitious Name Statement issued by the county is required.
9. If earnings are to be reported under an Employer Identification Number (EIN), please include a copy of pre-printed IRS documentation showing the EIN/Name Combination recognized by the IRS (SS-4 form, 147C form, or a copy of the Federal Tax Deposit Coupon are examples of acceptable pre-printed documents).

If further clarification is necessary, please include a cover letter with your application. This will ensure your application is processed timely and accurately and prevent claims, rejects, or incorrect payment. Please notify this department of any future changes to the information listed on this application.

An Independent Member of the Blue Shield Association C1645 (4/11)